United States Department of Labor
Employees' Compensation Appeals Board

S.T., Appellant	)	
and	)	**Docket No. 21-1060**
	)	**Issued: March 11, 2022**
DEPARTMENT OF VETERANS AFFAIRS, VA MEDICAL CENTER, Washington, DC, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 5, 2021 appellant filed a timely appeal from a February 2, 2021 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees'

[1] Appellant timely requested oral argument before the Board. 20 C.F.R. § 501.5(b). Pursuant to the Board's *Rules of Procedure*, oral argument may be held in the discretion of the Board. 20 C.F.R. § 501.5(a). In support of appellant's oral argument request, she asserted that oral argument should be granted because the evidence of record was sufficient to establish that she was totally disabled from work due to her accepted employment-related condition. The Board, in exercising its discretion, denies appellant's request for oral argument because the arguments on appeal can adequately be addressed in a decision based on a review of the case record. Oral argument in this appeal would further delay issuance of a Board decision and not serve a useful purpose. As such, the oral argument request is denied and this decision is based on the case record as submitted to the Board.

Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

ISSUE

The issue is whether appellant has met her burden of proof to establish disability from work for the period November 13, 2020 through January 30, 2021 causally related to her accepted March 23, 2020 employment injury.

FACTUAL HISTORY

On April 27, 2020 appellant, then a 60-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on March 23, 2020 she contracted COVID-19 while in the performance of duty. She stopped work on the date of injury and has not returned. On July 20, 2020 OWCP accepted the claim for COVID-19.

OWCP received hospital records dated April 2 through July 13, 2020, which indicated that appellant was admitted to the intensive care unit (ICU) on April 2, 2020 and treated for acute hypoxic respiratory failure and acute renal failure due to COVID-19. The hospital records also addressed her subsequent physical and occupational therapy.

In a June 22, 2020 letter, Dr. Anna-Carson Rimer Uhelski, an internist, advised appellant that she should not return to work while she was recovering in the hospital. She also advised that appellant could be in the hospital through 2020 with a possible return-to-work date of January 1, 2021.

Dr. Robert S. Mayer, Board-certified in physical medicine and rehabilitation, indicated in a letter dated July 15, 2020 that appellant could benefit from a home health aide six to eight hours per day over the next one to two months to assist her with the performance of activities of daily living (ADLs).

In an undated response to a questionnaire, appellant noted her symptoms and/or conditions of COVID-19, organ failure of the kidney, lungs, and heart, pneumonia in both lungs, high fever, coughing, and bacterial infections. She also noted that she was on a ventilator and an extracorporeal membrane oxygenation bypass portable machine for her lungs and heart and on dialysis for her kidneys. Additionally, appellant took blood pressure medication, underwent a tracheostomy, was incubated, and received blood transfusions. She indicated that her conditions were caused by her employment. Appellant further indicated that she was disabled from work for the period March 25 through December 31, 2020 due to her conditions.

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that, following the issuance of the February 2, 2021 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

On December 15 and 16, 2020 appellant filed claims for compensation (Form CA-7) for disability from work for the period November 13 through December 11, 2020.

OWCP, in a December 18, 2020 development letter, informed appellant of the deficiencies of her wage-loss compensation claim. It advised her of the type of medical evidence needed and afforded her 30 days to respond.

Appellant filed additional CA-7 forms for disability from work through January 30, 2021.

OWCP received additional medical evidence. In a progress note dated August 4, 2020, Dr. Daniel R. A. Sova, a physiatrist, noted appellant's history of injury and medical treatment. He discussed examination findings. Dr. Sova provided assessments that included no signs of anxiety, depression, or post-traumatic stress disorder (PTSD). He also noted a history of hypoxic respiratory failure, noting that a tracheostmy tube had been removed, acute renal failure, noting that appellant remained off dialysis, right and left upper extremity catheter-associated thrombosis, atrial fibrillation with rapid ventricular response (RVR), klebsiella pneumonia for which she had finished a course of treatment, Coagulase-negative staphylococci **(**CoNS) bacteremia, and that there was a concern for seizure for which she took medication. Dr. Sova noted that she denied any current COVID-19-related symptoms. He also noted that appellant received home physical and occupation therapy treatment and treatment from a speech language pathologist. Appellant reported that she was making progress with her physical function and endurance.

Dr. Ashral Fawzy, a pulmonologist, noted, in an August 12, 2020 progress note, that appellant was treated for COVID-19-related symptoms of shortness of breath and voice hoarseness, and screened for depression. He reported physical examination findings and diagnostic and laboratory test results. Dr. Fawzy provided assessments of dyspnea, hoarse voice, deep vein thromobosis (DVT), no significant depression or anxiety, 50 percent physical function, and adequate cognitive function and no symptoms of memory loss. In a November 11, 2020 progress note, he concluded that, cognitively, appellant performed poorly with respect to her memory, processing speed, and verbal fluency. Dr. Fawzy noted that appellant denied problems with mood, anxiety, trauma, or functional decline. He indicated that her scores suggested that she may benefit from a full neuropsychological examination given her pattern of cognitive deficits.

In a September 4, 2020 report, Dr. Robert A. Wise, Board-certified in internal medicine and pulmonology, noted that he performed a pulmonary function test, which demonstrated moderate restrictive ventilatory defect, severe gas transfer defect, and variable extrathoracic obstruction.

In a report of even date, Dr. Nathaniel Shalom and Dr. Stefan Zimmerman, both Board-certified in diagnostic radiology, performed a computerized tomography (CT) scan of appellant's chest. Dr. Shalom and Dr. Zimmerman provided an impression of peripheral reticulations, ground glass opacities, and consolidative opacities, which were compatible with the sequela of COVID-19 infection; ground glass that could represent mild residual inflammation, areas of reticulation and a cystic change compatible with mild fibrosis, either secondary to COVID-19 infection or preexisting; and additional multiple subcentimeter lymph nodes compatible with reactive change. These physicians also provided: impressions of coronary artery calcifications; dilatation of the main pulmonary artery, which may be seen in the setting of pulmonary hypertension; incidental

thyroid nodule measuring greater than or equal to 1.5 centimeters in a patient with age greater than or equal to 35, recommendation for an evaluation with a thyroid ultrasound on a nonemergent basis; postsurgical changes of sleeve gastrectomy; and findings suggestive of a small intralobar pulmonary sequestration in the inferomedial right lower lobe.

In a September 21, 2020 diagnostic report, Dr. Eva K. Ritzal, a Board-certified neurologist, conducted electroencephalogram (EEG) testing, finding that it was normal with no epileptiform discharges or lateralizing signs. She noted that this did not rule out the presence of a seizure disorder.

An October 7, 2020 progress note signed by Dr. George T. Kannarkat, a Board-certified internist, and Dr. Brett M. Morrison, a Board-certified neurologist, indicated that appellant was evaluated for seizures. Appellant's history of injury and medical treatment, physical examination findings and diagnostic test results were provided. Dr. Kannarkat and Dr. Morrison noted that appellant was recently very critically ill and that she had made a remarkable recovery. She had a seizure while critically ill and brain imaging was notable for subcortical T2 flair hyper intensities (non-specific, but may be chronic ischemic with superimposed changes in setting of critical illness) and diffuse micro hemorrhages (likely from extracorporeal membrane oxygenation). An EEG, which was performed while appellant was an inpatient, was diffusely slow, but there was no clear focality. Dr. Kannarkat and Dr. Morrison indicated that they would use an EEG to risk stratify given that she had some underlying structural etiology that could predispose her to seizure although seizure was only in the setting of her critical illness. As appellant was on anticoagulation for atrial fibrillation, a seizure in this setting could theoretically put her at risk for intracerebral hemorrhage so this will be weighed in a risk benefit analysis of continuing automated external defibrillators. Additionally, she had signs of proximal weakness in the right upper extremity and bilateral lower extremities, and bilateral foot drop, left greater than right. Appellant also had sensory loss and weakness in the left distal tibial distribution. There was no Tinel's sign over the tarsal tunnel. Dr. Kannarkat and Dr. Morrison related that if this continued to improve there was no need for evaluation as this was the likely sequela of her prolonged critical illness, compression from positioning, and multiple venous thrombotic events.

In an October 8, 2020 progress note, Dr. Lee M. Akst, a Board-certified otolaryngologist, reported appellant's history of injury and medical treatment. He discussed examination findings and provided an assessment of posterior glottic diastasis after prolonged intubation and tracheostomy secondary to COVID-19. In a report of even date, Dr. Grace Snow, an otolaryngologist, performed a transnasal videostrobolaryngoscopy to treat appellant's dysphonia.

In a progress note dated November 10, 2020, Dr. Sima Rozati, Board-certified in internal medicine and dermatology, provided findings on physical examination of appellant and diagnosed acne vulgaris, primary, hair loss, seborrheic dermatitis of the scalp, and post-inflammatory hyperpigmentation.

In a November 23, 2020 progress note, Dr. Nelson Maniscalco, a podiatrist, indicated that appellant presented with complaints of persistent left foot numbness. He reported findings on physical, neurological, and dermatologic examination. Dr. Maniscalco diagnosed left lower limb mononeuropathy and neuropathic left foot pain, gait abnormality, and history of COVID-19.

Dr. Sova, in an additional progress note dated December 1, 2020, reiterated his prior assessments of no signs of anxiety, depression, or PTSD, and he noted that appellant had been scheduled for an evaluation of her cognitive status. He noted that appellant had a history of hypoxic respiratory failure, right and left upper extremity catheter-associated thrombosis, atrial fibrillation with RVR, concern for seizures, and left foot numbness and intermittent pain in the first and fifth toes.

In a December 10, 2020 progress note, Dr. Zachary D. Berger, a Board-certified internist, diagnosed stage 3 chronic kidney disease, dyspnea on exertion, voice hoarseness, unspecified type of atrial fibrillation, history of DVT in adulthood, chronic anticoagulation, and left foot neuropathic pain.

A December 23, 2020 progress note from Dr. Vasanth Sathiyakumar, a cardiologist, reported appellant's history of injury and medical treatment. He discussed examination and reviewed laboratory test results. Dr. Sathiyakumar provided an assessment of essential hypertension, hyperlipdima, and obstructive sleep apnea.

Progress notes dated November 3 and 18, and December 15 and 29, 2020 from Kristine M. Pietsch, a certified speech language pathologist, provided an assessment that appellant presented with severe dysphonia secondary to posterior glottic diastasis that negatively impacted communication. Dr. Pietsch advised that appellant's prognosis was fair.

OWCP also received clinic treatment, and progress notes dated September 30, 2020 through January 8, 2021 signed by Caroline C. Griffin, a registered occupational therapist, Casey A. Houlihan, Allison Nogi, and Julia L. Falkenklous, physical therapists, and Blakeney T. Patterson, an occupational therapist.

By decision dated February 2, 2021, OWCP denied appellant's claim for disability. It found that the medical evidence of record was insufficient to establish disability from work during the claimed period due to the accepted employment injury.

LEGAL PRECEDENT

An employee seeking benefits under FECA[4] has the burden of proof to establish the essential elements of his or her claim, including that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[5] For each period of disability claimed, the employee has the burden of proof to establish that he or she was disabled

[4] *Supra* note 2.

[5] *See D.S.*, Docket No. 20-0638 (issued November 17, 2020); *F.H.*, Docket No. 18-0160 (issued August 23, 2019); *C.R.*, Docket No. 18-1805 (issued May 10, 2019); *Kathryn Haggerty*, 45 ECAB 383 (1994); *Elaine Pendleton*, 40 ECAB 1143 (1989). *See also* FECA Bulletin No. 20-05 (issued March 31, 2020) entitled *Federal Employees Contracting COVID-19 in Performance of Duty*, which provides in pertinent part: "DISABILITY: FECA pays compensation for partial or total disability of an employee resulting from injury in the performance of duty. Just as with other conditions/claims, disability is claimed by the filing of a CA-7, Claim for Compensation, with the employing agency and requires an incapacity because of an employment-related injury to earn wages."

from work as a result of the accepted employment injury.[6] Whether a particular injury causes an employee to become disabled from work, and the duration of that disability, are medical issues that must be proven by a preponderance of probative and reliable medical opinion evidence.[7]

Under FECA, the term disability means an incapacity because of an employment injury, to earn the wages the employee was receiving at the time of the injury.[8] When, however, the medical evidence establishes that the residuals or sequelae of an employment injury are such that, from a medical standpoint, prevent the employee from continuing in his or her employment, he or she is entitled to compensation for any loss of wages.[9]

To establish causal relationship between the disability claimed and the employment injury, an employee must submit rationalized medical evidence, based on a complete factual and medical background, supporting such causal relationship.[10] The opinion of the physician must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[11]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish disability from work for the period November 13, 2020 through January 30, 2021 causally related to her accepted March 23, 2020 employment injury.

In support of her claim for compensation, appellant submitted a June 22, 2020 opinion from Dr. Uhelski. Dr. Uhelski found that appellant could not work while she was recovering in the hospital and that she could be in the hospital through 2020. She advised that appellant could possibly return to work on January 1, 2021. Dr. Uhelski's opinion regarding appellant's disability status was speculative in nature. The Board has held that medical opinions that are equivocal or speculative in nature are of diminished probative value.[12] Thus, the Board finds that Dr. Uhelski's June 22, 2020 opinion is insufficient to establish appellant's disability claim.

The progress reports dated August 4 through December 23, 2020 from Drs. Sova, Fawzy, Kannarkat, Morrison, Rozati, Maniscalco, Berger, Akst, Snow, Wise, and Sathiyakumar addressed appellant's diagnosed conditions, including COVID-19, and her medical treatment. However,

[6] *See L.F.*, Docket No. 19-0324 (issued January 2, 2020); *T.L.*, Docket No. 18-0934 (issued May 8, 2019); *Fereidoon Kharabi*, 52 ECAB 291, 293 (2001).

[7] *See* 20 C.F.R. § 10.5(f); *N.M.*, Docket No. 18-0939 (issued December 6, 2018).

[8] *Id.* at § 10.5(f); *see, e.g.*, *G.T.*, 18-1369 (issued March 13, 2019); *Cheryl L. Decavitch*, 50 ECAB 397 (1999).

[9] *G.T., id.*; *Merle J. Marceau*, 53 ECAB 197 (2001).

[10] *See S.J.*, Docket No. 17-0828 (issued December 20, 2017); *Kathryn E. DeMarsh*, 56 ECAB 677 (2005).

[11] *C.B.*, Docket No. 18-0633 (issued November 16, 2018); *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[12] *See M.L.*, Docket No. 20-1682 (issued June 24, 2021).

these reports did not offer an opinion addressing whether appellant was totally disabled from work during the claimed period due to the accepted injury. As such, the Board finds that this medical evidence is of no probative value and insufficient to establish appellant's disability claim.[13]

Appellant also submitted a September 4, 2020 chest CT scan report and a September 21, 2020 EEG report. The Board has held, however, that diagnostic studies, standing alone, lack probative value on the issue of causal relationship as they do not address whether the accepted employment injury resulted in appellant's period of disability on specific dates.[14]

Progress notes from the speech language pathologists and physical and occupational therapists were also received. Speech pathologists, physical therapists, and occupational therapists are not considered physicians as defined under FECA.[15] As such, this evidence is also of no probative value and insufficient to establish the claim.

As noted, for each period of disability claimed, the employee has the burden of proof to establish that he or she was disabled from work during the claimed period due to the accepted employment injury.[16] As appellant has not submitted rationalized medical opinion evidence sufficient to establish employment-related disability during the period November 13, 2020 through January 30, 2021due to her accepted employment injury, the Board finds that she has not met her burden of proof to establish her claim.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

[13] Medical evidence that does not offer an opinion regarding the cause of an employee's condition or disability is of no probative value. *See L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

[14] *D.M.*, Docket No. 20-0548 (issued November 25, 2020); *O.C.*, Docket No. 20-0514 (issued October 8, 2020); *R.J.*, Docket No. 19-0179 (issued May 26, 2020).

[15] Section 8101(2) of FECA provides that the term physician includes "surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law." 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t). *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006) (lay individuals such as physician assistants, nurses, and physical therapists are not competent to render a medical opinion under FECA); *see also S.S.*, Docket No. 18-0081 (issued August 22, 2018); *P.Y.*, Docket No. 16-1324 (issued July 24, 2017) (a speech pathologist is not considered a physician under FECA); *F.H.*, *supra* note 5; *R.L.*, Docket No. 19-0440 (issued July 8, 2019) (a physical therapist is not considered a physician under FECA); *S.J.*, Docket No. 20-1061 (issued December 22, 2020); *J.R.*, Docket No. 19-0812 (issued September 29, 2020) (an occupational therapist is not considered a physician under FECA).

[16] *Supra* note 6.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish disability from work for the period November 13, 2020 through January 30, 2021, causally related to her accepted March 23, 2020 employment injury.[17]

ORDER

IT IS HEREBY ORDERED THAT the February 2, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 11, 2022
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[17] The Board notes that OWCP has not adjudicated appellant's claims for compensation for subsequent periods of disability causally related to her accepted employment injury.